

<b>Case Number:</b>	CM13-0018448		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	08/15/2005
<b>Decision Date:</b>	01/02/2014	<b>UR Denial Date:</b>	08/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury is 08/15/2005. The treating diagnosis is adhesive capsulitis. Treating diagnoses include status post left shoulder surgery, cervical bulges, thoracic sprain, lumbar disc extrusion with radiculopathy, right shoulder sprain, right elbow strain, left elbow strain, right knee internal derangement, compensatory left knee and ankle strain, status post right knee surgery in August 2011, and compensatory left knee strain. A physician request of 06/28/2013 requests a cold therapy unit. An accompanying physician treatment note reports pain, restricted motion, weakness in the shoulder, and discusses the diagnoses of right shoulder tendinitis with impingement, right shoulder synovitis, and right rotator cuff pathology. The request for treatment includes continuous passive motion and cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Practice Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**Decision rationale:** ACOEM Guidelines, Chapter 3 Treatment, page 48, states, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities

such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." More specifically, Official Disability Guidelines/Treatment of Workers' Compensation/Shoulder states regarding continuous-flow cryotherapy, "Recommended as an option after surgery, but not for nonsurgical treatment...Postoperative use generally may be up to 7 days." Thus, the guidelines in general do not support use of durable medical equipment for thermal modalities other than in the very acute phase of an injury. Per the guidelines cited, a cold therapy unit specifically is recommended for up to 7- to 8-day postoperative rental but not beyond that. The request for a cold therapy unit is not medically necessary and appropriate.